DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Supportive Living
DSL-2558 (Rev. 11/2002)

STATE OF WISCONSIN
Completion of this form meets the requirements of the State/County contract specified under the Wisconsin Statutes.
S. 46.03 (12), 46.275, 46.278 (2)

COUNTY CRITICAL INCIDENT REPORT

Instructions: This form must be completed in its entirety. Additional information may be attached to supplement information provided on the report form. FAX this form to the Bureau of Developmental Disabilities Services (BDDS) Critical Incident Contact in Central Office assigned to this individual within 30 days of the incident. Additional material that is not available due to reasons beyond the county's control may be sent under cover letter at a later date. Personally identifiable information on this form is collected for the purpose of improving quality of services and will only be used for that purpose.

1. Date Form Completed (mm/dd/yyyy)

2. Name - Primary Community Integration Specialist

3. Report Type (Check all appropriate)
☐ Original ☐ Update ☐ Correction ☐ Review Closed

4. Date Critical Incident Review Closed (mm/dd/yyyy)

PERSON COMPLETING FORM INFORMATION

5. Name - Last

Name - First

Title

6. Name - Agency

7. Telephone Number

CASE MANAGER INFORMATION (If different from above)

8. Name - Last

Name - First

9. Telephone Number

10. Case Manager ID Number

PARTICIPANT INFORMATION

11. Name - Last

Name - First

MI

12. Birthdate (mm/dd/yyyy)

13. Gender
☐ Male ☐ Female

14. Medicaid Number

15. Telephone Number - Residential

16. Program
☐ BIW ☐ CIP 1A ☐ CIP 1B ☐ CSLA ☐ Other

EVENT

17. Date of Event (mm/dd/yyyy)

18. Location Event Occurred (Street, City, State, Zip Code)

19. Type of Setting

Residence
- ☐ Participant's private home or apartment
- ☐ Adult family home (1-2 beds)
- ☐ Adult family home (3-4 beds)
- ☐ CBRF
- ☐ Children's foster home

Other
- ☐ Work / day program
- ☐ Community work site
- ☐ Community setting; e.g., park, store, etc.
- ☐ Transport
- ☐ Another person's residence
- ☐ Other - Specify: _____

20. Allegation of caregiver misconduct?
☐ Yes ☐ No

21. Name - Provider Agency

22. Address - Provider Agency (Street, City, State, Zip Code)

INITIAL REPORT

23. Provide a brief description of initial event or allegation. Send additional documentation only if necessary.

24. How did the reporter learn of this event?

If hospitalization or medical treatment was needed, complete the following.

25. Date of Treatment (mm/dd/yyyy)	26. Name - Institution Where Treatment Was Obtained

27. Reason for admission / treatment

28. Outcome of treatment

If the participant died, complete the following:

29. Date of Death (mm/dd/yyyy)	30. Official cause of death as reported on the death certificate

31. Check applicable event type(s) / allegations below. Check "Alleged Only" if there is doubt that the event occurred.

Event Type / Allegation	Alleged Only
Abuse	
☐ Mental / emotional	☐
☐ Physical	☐
☐ Sexual	☐
☐ Verbal	☐
Death	
☐ Accidental	☐
☐ Anticipated	☐
☐ Related to psychotropic medication*	☐
☐ Related to restraint*	☐
☐ Related to suicide*	☐
☐ Unanticipated medical	☐
Note: *Deaths related to above factors in certain facilities must be reported to the Department / DSL Death Review Committee within 24 hours.	
Hospitalization	
☐ Emergency medical	☐
☐ Mental health / behavior	☐
Law Authority Contact	
☐ Commission of crime	☐
☐ Victim of crime	☐
Misappropriation	
☐ Person's funds	☐
☐ Person's property	☐

Event Type / Allegation	Alleged Only
Neglect	
☐ Environmental	☐
☐ Fail to follow plan / poor care	☐
☐ Medical / failure to seek	☐
☐ Nutrition	☐
☐ Self-neglect	☐
☐ Unanticipated absence of provider	☐
Residence Damage	
☐ Fire	☐
☐ Other	☐
☐ Weather	☐
Other	
☐ Serious illness / injury / accident	☐
☐ Significant behavior that placed others at risk	☐
☐ Suicide attempt	☐
☐ Other rights violations	☐
☐ Unanticipated absence of participant	☐

32. Contact checklist. Check all persons / agencies contact by county, provider and person / guardian. Fill in the first date contacted in regard to this event. *Contacts may be required depending upon circumstances.

☐	**A.**	**Adult Protective Services**	
		Name - Agency	Date - First Contact (mm/dd/yyyy)
		Name - Contact Person	Telephone Number - Agency
☐	**B.**	**BDDS / Community Integration Specialist (CIS)** (Required)	
		Name	Date - First Contact (mm/dd/yyyy)
☐	**C.**	**Caregivers Investigation*** (608) 261-7651	Date - First Contact (mm/dd/yyyy)
☐	**D.**	**Child Abuse**	
		Name - Agency	Date - First Contact (mm/dd/yyyy)
☐	**E.**	**County Case Manager**	
		Name -Contact Person	Date - First Contact (mm/dd/yyyy)
☐	**F.**	**Elder Abuse**	
		Name - Agency	Date - First Contact (mm/dd/yyyy)
☐	**G.**	**Guardian** (Required)	
		Name	Date - First Contact (mm/dd/yyyy)
☐	**H.**	**Law Enforcement Agency**	
		Name - Agency	Date - First Contact (mm/dd/yyyy)
☐	**I.**	**Licensing ***	
		☐ **Adult** Name - Agency	Date - First Contact (mm/dd/yyyy)
		☐ **Children's** Name - Agency	Date - First Contact (mm/dd/yyyy)
☐	**J.**	**Other Providers** If additional space is needed, attach separate sheet.	
		Name - Agency	Date - First Contact (mm/dd/yyyy)
		Name - Agency	Date - First Contact (mm/dd/yyyy)
☐	**K.**	**Physician**	Date - First Contact (mm/dd/yyyy)
☐	**L.**	**Area Administration**	
		Name	Date - First Contact (mm/dd/yyyy)
☐	**M.**	**Residential Support Provider**	Date - First Contact (mm/dd/yyyy)
☐	**N.**	**Residential Support Provider**	Date - First Contact (mm/dd/yyyy)
☐	**O.**	**Wisconsin Coalition for Advocacy** Telephone Number. - Madison (608) 267-0214 Telephone Number - Milwaukee (414) 342-8700	Date - First Contact (mm/dd/yyyy)

33. Response Summary. Check all that apply; send updates as needed.

☐ **Nothing changed**

Case Management
☐ Additional services added to plan
☐ Higher level monitoring
☐ Terminated waiver participation
☐ Changed - New case manager is: _____

Day / Work Provider
☐ Same agency - staff changed
☐ Same agency - staff training provided
☐ Same agency - staff added
☐ Changed - New provider is: _____

Guardian
☐ Changed - New guardian is: _____

Telephone number: _____

Residential Provider
☐ Same agency - staff changed
☐ Same agency - staff training provided
☐ Same agency - staff added
☐ Changed - New provider is: _____

☐ **HFS 94 grievance filed**

☐ **Other** - Specify: _____

34. Narrative CI outcome.

35. In the internal reviews of this event, were there any recommendations offered to improve the quality of care for other waiver participants or changes in policy / procedure? If so, summarize what the recommendations / changes are and the plans for implementing them.

FOR BDDS USE ONLY

36. Name - Participant	37. Medicaid Number

38. Name - Staff Member Who Completed This Form	39. Event Date	40. Review Date

41. Check applicable event type(s) / allegations below. Check "Alleged Only" if there is doubt that the event occurred.

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☐ Physical	☐
☐ Sexual	☐
☐ Verbal	☐
Death	
☐ Accidental	☐
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Law Authority Contact	
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Misappropriation	
☐ Person's funds	☐
☐ Person's property	☐

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☐ Unanticipated absence of provider	☐
Residence Damage	
☐ Fire	☐
☐ Other	☐
☐ Weather	☐
Other	
☐ Serious illness / injury / accident	☐
☐ Significant behavior that placed others at risk	☐
☐ Suicide attempt	☐
☐ Other rights violations	☐
☐ Unanticipated absence of participant	☐

42. BDDS Response Summary. Check all that apply and the date completed.

	Date Completed		Date Completed
☐ None			
☐ Informal follow-up	_____	☐ Caregiver referral	_____
☐ Behavior consult	_____	☐ Formal POC issued	_____
☐ Provide training	_____	☐ Formal POC issued	_____
☐ Additional field visit	_____	☐ ISP revision	_____
☐ Licensing referral	_____	☐ CI review closed	_____

43. Provide any additional information about the event you need to add to the record.

44. Review Planning

	Date Due
☐ Plan of correction	_____
☐ Targeted review	_____

45. ☐ Yes ☐ No Are there attachments in the paper file?